No. 06-419

In the Supreme Court of the United States

PEDIATRIC SPECIALTY CARE, INC., *et al.*,
Petitioners,

v.

ARKANSAS DEPARTMENT
OF HUMAN SERVICES, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

BRIEF IN OPPOSITION

Michael R. Rainwater
RAINWATER, HOLT
& SEXTON, P.A.
P.O. Box 17250
Little Rock, AR 72222-7250
(501) 868-2500

James W. Erwin
Counsel of Record
Harry W. Wellford
THOMPSON COBURN LLP
One US Bank Plaza
St. Louis, MO 63101
(314) 552-6032

Counsel for Respondent
Arkansas Foundation for Medical Care, Inc.

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

COUNTER-STATEMENT OF THE QUESTION PRESENTED

The statute authorizing States to contract with federally-certified quality improvement organizations (formerly known as "peer review organizations") to conduct reviews of request for Medicaid benefits to determine whether the requested services are "medically necessary" provides that "any data or information acquired by any such organization . . . shall be held in confidence and shall not be disclosed to any person" with certain exceptions. 42 U.S.C. § 1320c-9(a). It further directs the issuance of regulations "to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care. 42 U.S.C. § 1320c-9(a)(1).

Does the statute authorize regulations that prohibit disclosure without the reviewer's consent of the identity of health care practitioners who review a request for Medicaid services and conclude that the requested services are not "medically necessary" in a State administrative proceeding challenging the denial of Medicaid benefits?

RULE 29.6 STATEMENT

The Arkansas Foundation for Medical Care, Inc. is an Arkansas corporation. It has no parent corporation, and no publicly-owned corporation owns any of its stock.

TABLE OF CONTENTS

COUNTER-STATEMENT OF THE QUESTION PRESENTED i

RULE 29.6 STATEMENT ii

TABLE OF CONTENTS iii

TABLE OF AUTHORITIES iv

STATUTORY PROVISIONS INVOLVED 1

STATEMENT OF THE CASE 1

REASONS FOR DENYING THE PETITION 5

CONCLUSION 11

APPENDIX

Appendix A: Statutory Provisions: Ark. Code Ann. § 25-15-208; Ark. Code Ann. § 25-15-210; Ark. Code Ann. § 25-15-212 . . . . . 1b

Appendix B: Excerpts from April 5, 2004 Motion Hearing 7b

TABLE OF AUTHORITIES

Cases

Chevron U.S.A. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984) 5, 7, 10

Featherston v. Stanton, 626 F.2d 591 (7th Cir. 1980) . . 9

Goldberg v. Kelly, 397 U.S. 254 (1970) 9

Public Citizen, Inc. v. U.S. Department of Health and Human Services, 357 U.S.App.D.C. 1, 332 F.2d 654 (D.C. Cir. 2003) 6, 7

Pediatric Specialty Care, Inc. v. Arkansas Department of Human Services, 443 F.3d 1005 (8th Cir. 2006), *petition for cert. filed sub nom., Selig v. Pediatric Specialty Care, Inc.*, 75 U.S.L.W. 3177 (U.S., Sep. 20, 2006) (No. 06-415) 3, 4

Williams v. Scott, 278 Ark. 453, 647 S.W.2d 115 (1983) 3

Statutes

Ark. Code. Ann. § 25-15-208 . . . . . 1, 2

Ark. Code Ann. § 25-15-208(4) 3

Ark. Code Ann. § 25-15-210 3

Ark. Code. Ann. § 25-15-210(b)(2) 1

Ark. Code. Ann. § 25-15-212 1

Ark. Code Ann. § 25-15-212(b) 3

Ark. Code Ann. § 25-15-212(h) 3

42 C.F.R. § 480.101(a) 8

42 C.F.R. § 480.133(a)(B)(iii) 8

42 C.F.R. § 480.139(b)(2) 8

42 U.S.C. §§ 1320c *et seq.* 1

42 U.S.C. § 1320c-3(14) 6

42 U.S.C. § 1320c-5(a)(1) 1

42 U.S.C. § 1320c-9 7

42 U.S.C. § 1320c-9(a) 8, 10

42 U.S.C. § 1320c-9(a)(1) 1

42 U.S.C. § 1320c-9(a)(2) . . . . . *passim*

42 U.S.C. § 1320c-9(d) 7

42 U.S.C. § 1396a(a)(3) 2

42 U.S.C. § 1396a(a)(30)(A) 3

STATUTORY PROVISIONS INVOLVED

In addition to the statutes and regulations cited in the petition, the relevant portions of the following statutes are reproduced at Resp. App. A, at 1b: Ark. Code Ann. § 25-15-208, Ark. Code Ann. § 25-15-210(b)(2), and Ark. Code Ann. 25-15-212.

STATEMENT OF THE CASE

Respondent Arkansas Foundation for Medical Care, Inc. ("AFMC") is a federally-certified quality improvement organization ("QIO"). AFMC contracted with the Arkansas Department of Human Services ("ADHS") under 42 U.S.C. §§ 1320c *et seq.*, to, among other contractual duties, review requests for authorization of certain medical services to be paid by Medicaid. In making these determinations, AFMC contracted with local physicians, Board-certified in the relevant field, to decide whether the services requested are medically necessary as required by 42 U.S.C. § 1320c-5(a)(1).

The review process works like this: the health care provider sends a request for approval of services to AFMC for a determination of whether the services are medically necessary. The request is accompanied by the patient's records. The request is initially reviewed by an AFMC-employed nurse. If the request meets certain criteria, the nurse approves the request. If the request fails to meet the screening criteria established by the AFMC medical director, the file is sent to a Board-certified physician in the relevant field — a "reviewer." The physician-reviewer evaluates the records, and makes a determination whether the services are medically necessary. If the reviewer decides that some or all of the requested services are not medically necessary, the

reviewer issues a recommendation that the request be denied, along with a summary of the reasons for the recommendation. The AFMC medical director makes the final determination, taking the recommendation into account.

The AFMC medical director signs the decision, and notifies the health care provider making the request of the denial or partial denial. The provider may request reconsideration of an adverse decision. If such a request is made, the entire file is given to a second Board-certified physician-reviewer. The second reviewer may approve additional services, but may not deny any services already approved by the first reviewer. If the provider does not timely request reconsideration, or if the reconsideration results in a full or partial denial of the request, AFMC notifies the patient of the decision. The denial notices are signed by AFMC's medical director, who is also a physician. Although AFMC does not disclose the name of the reviewing physicians, the medical director's identity is not confidential.

The patient may file an appeal of the decision as required by the "fair hearing" provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(3). (In Arkansas, a provider may now also appeal an adverse decision, and avail itself of the entire appellate process.) The administrative hearings are conducted in accordance with the provisions of the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-208. The administrative law judge decides the medical necessity of the requested services *de novo*. It is not an appeal in the classic sense. Rather, it is another opportunity for the patient to make the case for approval of payment for the services requested.

The administrative law judge has available the patient's medical records, *i.e.*, the same records given to the physician-

reviewer. The patient-applicant may call witnesses and offer additional evidence in support of the appeal. Ark. Code Ann. § 25-15-208(4). The patient may — and some have — subpoena AFMC's medical director to testify. The administrative law judge makes findings of fact and conclusions of law. Ark. Code Ann. § 25-15-210.

If the patient is dissatisfied with the administrative decision, he or she may appeal to the circuit court. Ark. Code Ann. § 25-15-212(b). The court may affirm, reverse, modify, or remand the case. Ark. Code Ann. § 25-15-212(h). The court decides whether the administrative decision is supported by substantial evidence, or whether it is arbitrary, capricious, or characterized by an abuse of discretion. *See id.*

The patient may, if dissatisfied with the circuit court's judgment, appeal to the Arkansas appellate courts. The appellate courts apply the same standard of review to the administrative decision as the circuit court. The Arkansas courts do not regard the administrative proceedings in connection with the denial of Medicaid benefits to be "truly adversary" because there is no burden on the State "to investigate the appellant's claim and introduce rebutting proof." *Williams v. Scott*, 278 Ark. 453, 455, 647 S.W.2d 115, 116 (1983).

This case involves Child Health Management Services ("CHMS"). CHMS providers offer certain services that the State of Arkansas has agreed to pay for under its Medicaid plan, if the services are medically necessary. Petitioners are three providers of CHMS services and two recipients of CHMS services. Whether the providers or recipients have a private right of action under § 1396a(a)(30)(A) is one of the issues before this Court in a related case, *Pediatric Specialty Care, Inc. v. Arkansas Department of Human Services*, 443

F.3d 1005 (8th Cir. 2006), *petition for cert. filed sub nom., Selig v. Pediatric Specialty Care, Inc.*, 75 U.S.L.W. 3177 (U.S., Sep. 20, 2006)(No. 06-415).

The primary dispute in that case is whether the providers and recipients may sue State Medicaid officials for damages when AFMC physician-reviewers declined to authorize the CHMS services requested because they decided the full amount of services sought were not medically necessary. The petitioners allege that every patient needed 6 hours of CHMS services per day to achieve maximum reduction of their physical or mental disabilities. The AFMC physician-reviewers, on the other hand, determined that no more than 3.5 to 4 hours of CHMS services per day was medically necessary.

In course of the underlying litigation in the district court, one of the petitioners — Tomorrow's Child Learning Center, LLC — filed a motion for a "temporary restraining order" (construed by the courts below as a motion for a preliminary injunction) seeking an order directing that AFMC and ADHS disclose the names of the nurses and physicians who reviewed each patient's request for CHMS services.

The issue did not arise in the context of discovery under the federal rules. Likewise, none of the petitioners (including Tomorrow's Child, the movant) alleged that they or their patients were currently involved in a proceeding at either the administrative or circuit court level where they had sought, but had been denied, disclosure of the identity of the nurses or physicians who had reviewed any particular request for CHMS services. Indeed, none of the individual petitioners were eligible for Medicaid services at the time the petitioners amended the complaint to raise the question of whether 6

hours or 3.5 to 4 hours of CHMS services was medically necessary.

What the petitioners do not know, and what was at issue in the courts below regarding the injunction, is which physician reviewed any particular patient's application. The district court's injunction held that petitioners "may discover the name, qualifications, and identity of each peer review physician and advisor who participated in the denial of medical benefits, based on the premise that the care did not meet medical necessity requirements." Pet. App. at 5a.

The district court, after first denying the preliminary injunction, *sua sponte* changed its mind. It found the federal regulations that prohibited disclosure of the identity of the physician who reviewed any particular request to be invalid. The court of appeals reversed, holding that the United States Department of Health and Human Services did not exceed its authority in issuing the regulations that prohibit disclosure of the identity of the physician-reviewers. The court held that the Department's regulations were entitled to deference under *Chevron U.S.A. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

REASONS FOR DENYING THE PETITION

Petitioners do not suggest that the decision below conflicts with any prior decision of any federal court, trial or appellate. Indeed, there is no conflict because the decision below appears to be the first time any federal court has considered whether the federal regulations implementing the confidentiality provisions of the QIO statute relating to "medical necessity" decisions are valid. The regulations have been in place for more than twenty years. During that time no one has ever questioned their validity or contended that they

were denied a "fair hearing" at the State administrative level, or under a State's system of judicial review, because they did not know the identity of the physician reviewing their request for Medicaid benefits.

Petitioners do not explain why procedural due process requires that they be given such information, especially in light of the fact that all of the documents reviewed by the AFMC physician-reviewer are provided to the decision-makers at the State administrative level and on judicial review. To the extent the patient needs to cross examine a witness in the State administrative hearing, AFMC's medical director is subject to subpoena for that purpose.

While we do not dispute that reviewer confidentiality is an important feature of the statutory and regulatory scheme, there simply is no difference of opinion among the courts below as to what is permitted and what is not. Petitioners cite *Public Citizen, Inc. v. U.S. Department of Health and Human Services*, 357 U.S.App.D.C. 1, 332 F.2d 654 (D.C. Cir. 2003) for the proposition that 42 U.S.C. § 1320c-9(a)(2) authorizes the Secretary to issue regulations that promulgate exceptions to the general nondisclosure requirements of the statute, rather than promulgate the Secretary's own nondisclosure requirements. *See id.*, 357 U.S.App. D.C. at 11, 332 F.2d at 664. *Public Citizen* does not conflict with the decision below, either directly or indirectly.

Public Citizen did not involve disclosure of information relating to a "medical necessity" determination. Rather, it was concerned with a "quality review" of a complaint by a specific individual against a specific doctor under § 1320c-3(14). As the court noted, there was no regulation that "interprets or even mentions § 1320c-3(14)." *Id.*, 357

U.S.App.D.C. at 6, 332 F.3d at 659. There are such regulations regarding "medical necessity" determinations.

The regulation the Secretary sought to apply in *Public Citizen* was issued before the particular subsection at issue was enacted. Thus, the government conceded that the regulation provided no basis for *Chevron* deference. Here, however, as the court of appeals noted, "[s]ince § 42 U.S.C. § 1320c-9's most recent amendment, HHS has reconsidered and amended the confidentiality provisions of its regulations, such that information could now be disclosed with the written consent of a medical practitioner or peer reviewer." *See* 444 F.3d at 995; Pet. App. at 9a. Thus, the court held, the confidentiality regulations were entitled to deference. *See id.*

Moreover, petitioners' argument that the only relevant provision is § 1320c-9(d) ignores the general nondisclosure rule of § 1320c-9(a). That section provides that "[*a*]*ny data or information* acquired by [a QIO] in the exercise of its duties and functions be held in confidence and *shall not be disclosed to any person*" except to the extent necessary to carry out the purposes of the statute, "to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care," to assist government agencies in the investigation of fraud, to protect the public health, or to assist in health care planning. (Emphasis added.) Thus, the statute protects all such information from disclosure unless an exception applies.

Section 1320c-9(a)(2) gives the Secretary the power to decide when disclosures will protect the rights and interests of patients, health care practitioners, and health care providers. Physician-reviewers for QIO's are "health care practitioners." Thus, Congress expressly gave the Secretary the discretion to take into account the need to protect their rights, and to

balance those needs against the needs of patients challenging "medical necessity" decisions.

In the exercise of that discretion, the Secretary determined that confidential information includes information that "explicitly or implicitly identifies an individual patient, practitioner, or reviewer." 42 C.F.R. § 480.101(a). Petitioners do not explain how that is inconsistent with § 1320c-9(a)(2). The regulations permit disclosure of information on a reviewer only with that person's consent. 42 C.F.R. § 480.133(a)(B)(iii). The QIO must, however, disclose the reasons for any denial of benefits. 42 C.F.R. § 480.139(b)(2). The disclosure must include "the detailed facts, findings and conclusions supporting the QIO's determination," without disclosing "the opinions or judgments of a particular individual or practitioner." *Id.* Again, this regulation is consistent with the general presumption of nondisclosure in § 1320c-9(a).

There are good reasons to protect the identity of the reviewing physicians. The reviewers are local doctors who practice in the same state as the doctors whose requests for authorization of Medicaid services they are reviewing. If the fact that they denied a particular request for services was made known, the doctors could be subject to peer pressure from their colleagues, adverse publicity in the press, or even reprisals from disgruntled applicants. The executive vice-president of the Arkansas Medical Society, for example, testified that disclosure of which reviewer denied which claim would discourage qualified physicians from participating at all. Resp. App., at 8b-9b.

Moreover, petitioners' apparent desire to subject the reviewers to cross examination in cases where CHMS benefits were denied or reduced could potentially mean that the Board-

certified pediatricians who agreed to be reviewers would constantly be taken away from their own practice to justify their decisions. And this would be done in proceedings where the administrative law judge has exactly the same information to consider as the reviewer had. It is important to recall that the physician-reviewers do not make the final decision. That is made by AFMC's medical director, whose identity is known, and who is available to testify if any party chooses to call him as a witness.

The reviewers in this case stand in virtually the same position as those in *Featherston v. Stanton*, 626 F.2d 591 (7th Cir. 1980). In *Featherston*, the plaintiffs sought dental benefits under Indiana's Medicaid program. Under Indiana's system, the request was initially reviewed by a panel of dentists similar in function to the physician-reviewers here. When the panel denied their requests, plaintiffs filed an appeal that was heard by an administrative hearing officer. Plaintiffs sought to cross examine the members of the dental panels because they were "expert witnesses" against them.

The Seventh Circuit, however, concluded that the function of the panels demonstrated that they were not "adverse witnesses" subject to cross examination as required by the hearing regulations, or by the due process standards of *Goldberg v. Kelly*, 397 U.S. 254 (1970). "Rather than functioning as adversaries to plaintiffs' claims, the initial review panels act as impartial assessors of plaintiffs' medical and social histories and as adjudicators of their entitlement to benefits." 626 F.2d at 594. The court pointed out that the reviewers are no more "adverse witnesses" than a district judge is in a subsequent appeal. *See id.* at 594 n.3.

Because they act in a similar adjudicative capacity, the court held that the initial review panels were required to give

a reasoned basis for their decisions. *See id.* at 594-595. Here that is not a problem, and, indeed, the petitioners have never complained that the reasons given for reduction or denial of benefits was not detailed enough. (They do, however, disagree with the substance of the reasons given for not approving the full amount of CHMS services requested.)

Finally, § 1320c-9(a) expressly delegated to the Secretary the power to issue regulations that governed when and what type of confidential information should be disclosed. The Secretary decided that the general nondisclosure rule of § 1320c-9(a) should apply to the identity of physician reviewers, unless they expressly consented to disclosure of their identity to patients and other non-governmental entities. When Congress makes such a delegation, the regulations are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute. *Chevron U.S.A. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844 (1984).

Nothing in the decision below is contrary to any decision of this court, another circuit court of appeals, or even any district court (except the one whose decision was reversed). The decision, at a minimum, correctly gave *Chevron* deference to the confidentiality regulations.

The protection of the identity of physicians who are reviewing the requests of their peers for medical necessity is needed to insure objectivity, to insulate the reviewers from improper influence from their peers and colleagues, to encourage qualified physicians to participate in the process without fear that they will be hauled into depositions or trials to testify against their peers, and to avoid possible harassment or undue public pressure to approve Medicaid payments for services that are not medically necessary.

Physician reviewers are "health care practitioners' too. *See* § 1320c-9(a)(2). They play an important role in the delivery of medical care to Medicaid recipients — the determination that the care that Medicaid pays for is "medically necessary." The protection of their identity is vital to the effective functioning of the system.

The decision below raises no issues worthy of review by this Court. There is no long-standing conflict among the circuits about this issue — indeed, there is no conflict at all. The Eighth Circuit merely affirmed that the process that has been followed for more than twenty years without question should remain in place.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

Respectfully submitted,

James W. Erwin
Counsel of Record
Harry W. Wellford
THOMPSON COBURN LLP
One US Bank Plaza
St. Louis, Missouri 63101
(314) 552-6032

Michael R. Rainwater
RAINWATER, HOLT &
SEXTON, P.A.
P.O. Box 17250
Little Rock, Arkansas 72222-7250
(501) 868-2500

Counsel for Respondent
Arkansas Foundation for
Medical Care, Inc.

January 11, 2007

APPENDIX

APPENDIX A

Ark. Code Ann. § 25-15-208. Contested cases; notice; hearings; records

(a) In every case of adjudication;

(1) All parties shall be afforded an opportunity for hearing after reasonable notice.

(2) The notice shall include:

(A) A statement of the time, place, and nature of the hearing;

(B) A statement of the legal authority and jurisdiction under which the hearing is to be held;

(C) A short and plain statement of the matters of fact and law asserted.

(3) In every case of adjudication wherein an agency seeks to revoke, suspend, or otherwise sanction a license or permit holder, the agency or its attorney, upon the request of the license or permit holder, must provide the following information prior to conducting a hearing of adjudication:

(A) The names and addresses of persons whom the agency intends to call as witnesses at any hearing;

(B) Any written or recorded statements and the substance of any oral statements made by the license or permit holder, or a copy of the same;

(C) Any reports or statements of experts, made in connection with the particular case, including results of physical or mental examinations, scientific tests, experiments, or comparisons, or copies of the same;

(D) Any books, papers, documents, photographs, or tangible objects which the agency intends to use in any hearing or which were obtained from or belong to the license or permit holder, or copies of the same;

(E) Disclosure shall not be required of research or records, correspondence, reports, or memoranda to the extent that they contain the opinions, theories, or conclusions of the attorney for the agency or members of his staff or other state agents.

(4) Opportunity shall be afforded all parties to respond and present evidence and argument on all issues involved.

(5) The record shall include:

(A) All pleadings, motions, and intermediate rulings;

(B) Evidence received or considered, including, on request of any party, a transcript of oral proceedings or any part thereof;

(C) A statement of matters officially noticed;

(D) Offers of proof, objections, and rulings thereon;

(E) Proposed findings and exceptions thereto; and

(F) All staff memoranda or data submitted to the hearing officer or members of an agency in connection with their consideration of the case.

(6) Findings of fact shall be based exclusively on the evidence and on matters officially noticed.

(7) If the agency is authorized by law to issue subpoenas for the attendance and testimony of witnesses and the production of documents or things, then any party shall to the same extent be so authorized, and the agency shall issue a subpoena forthwith on written application thereof.

(b) Nothing in this subchapter shall prohibit informal disposition by stipulation, settlement, consent order, or default.

Ark. Code Ann. § 25-15-210. Decisions and orders

(2) A final decision shall include findings of fact and conclusions of law, separately stated. Findings of fact, if set forth in statutory language, shall be accompanied by a concise and explicit statement of the underlying facts supporting the findings. If, in accordance with agency rules, a party submitted proposed findings of fact, the decision shall include a ruling upon each proposed finding.

Ark. Code Ann. § 25-15-212. Administrative adjudication -- Judicial review

(a) In cases of adjudication, any person, except an inmate under sentence to the custody of the Department of Correction, who considers himself or herself injured in his or her person, business, or property by final agency action shall be entitled to judicial review of the action under this subchapter. Nothing in this section shall be construed to limit other means of review provided by law.

(b)(1) Proceedings for review shall be instituted by filing a petition within thirty (30) days after service upon petitioner of the agency's final decision in:

(A) The circuit court of any county in which the petitioner resides or does business; or

(B) Pulaski County Circuit Court.

(2) Copies of the petition shall be served upon the agency and all other parties of record in accordance with the Arkansas Rules of Civil Procedure.

(3) In its discretion, the court may permit other interested persons to intervene.

(c) The filing of the petition does not automatically stay enforcement of the agency decision, but the agency or reviewing court may do so upon such terms as may be just. However, on review of disciplinary orders issued by professional licensing boards governing professions of the healing arts, the reviewing court, only after notice and hearing, may issue all necessary and appropriate process to

postpone the effective date of an agency action or to preserve status or rights pending conclusion of review proceedings.

(d)(1) Within thirty (30) days after service of the petition or within such further time as the court may allow but not exceeding an aggregate of ninety (90) days, the agency shall transmit to the reviewing court the original or a certified copy of the entire record of the proceeding under review.

(2) The cost of the preparation of the record shall be borne by the agency. However, the cost of the record shall be recovered from the appealing party if the agency is the prevailing party.

(3) By stipulation of all parties to the review proceeding, the record may be shortened. Any party unreasonably refusing to stipulate to limit the record may be taxed by the court for the additional costs.

(4) The court may require or permit subsequent corrections or additions to the record.

(e) If review proceedings have been instituted in two (2) or more circuit courts with respect to the same order, the agency concerned shall file the record in the court in which a proceeding was first instituted. The other courts in which the proceedings are pending shall thereupon transfer them to the court in which the record has been filed.

(f) If before the date set for hearing, application is made to the court for leave to present additional evidence and the court finds that the evidence is material and that there were good reasons for failure to present it in the proceeding before the agency, the court may order that the additional evidence be taken before the agency upon any conditions which may be

just. The agency may modify its findings and decision by reason of the additional evidence and shall file that evidence and any modifications, new findings, or decisions with the reviewing court.

(g) The review shall be conducted by the court without a jury and shall be confined to the record, except that in cases of alleged irregularities in procedure before the agency not shown in the record, testimony may be taken before the court. The court shall, upon request, hear oral argument and receive written briefs.

(h) The court may affirm the decision of the agency or remand the case for further proceedings. It may reverse or modify the decision if the substantial rights of the petitioner have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:

(1) In violation of constitutional or statutory provisions;

(2) In excess of the agency's statutory authority;

(3) Made upon lawful procedure;

(4) Affected by other error or law;

(5) Not supported by substantial evidence of record; or

(6) Arbitrary, capricious, or characterized by abuse of discretion.

(i) Any agency order which is affirmed or affirmed in part by the court shall be a final judgment subject to writ of garnishment or execution to the extent it is affirmed.

APPENDIX B

Excerpts from April 5, 2004 Motion Hearing

DAVID WROTEN, ARKANSAS DHS DEFENDANTS' WITNESS, DULY SWORN

DIRECT EXAMINATION

BY MR. HOPKINS:

Q. What's your name?

A. David Wroten.

Q. What is your occupation, Mr. Wroten?

A. I'm the assistant executive vice-president for the Arkansas Medical Society.

Q. How long have you held that position?

A. 20 years.

Q. What is the Arkansas Medical Society?

A. It's the professional association that represents the physicians of Arkansas.

Q. And you represent that association, so, in turn, you represent the physicians?

A. Yes, I do.

Q. Does the Medical Society advocate on behalf of physicians in connection with governmental programs such as Medicaid?

A. Yes, we do.

Q. Are you generally familiar with the Medicaid program because of your advocacy role?

A. Very familiar, yes.

* * *

Q. Sure. Isn't it true that the Arkansas Medical Society has tried to garner the support of its individual doctor members to oppose the plaintiffs' claim in this case that the doctors and nurses employed by AFMC should be disclosed in these denial letters that are issued so that they can be subpoenaed and questioned on appeal?

A. Well, we are opposed to those physicians' names being presented, yes.

Q. Why?

A. Because if in every case that comes up and every trial that comes up or every judicial hearing or administrative hearing, if the names of the physician reviewers were to be made public, then the bottom line is, no physician would agree to participate in the process.

THE COURT: Why?

BY MR. BOWEN:

Q. Why?

A. Because it's time out of their practice, it's pressure, peer pressure from others, peer pressure from the local press: You deny the service? How dare you deny a service? We know that family, and we feel like that family is needy and that they need help.

THE COURT: The Medical Society feels like that this secret review is preferable?

THE WITNESS: Well, I don't believe it's a secretive review, but the identification of the reviewers is. They are all board certified in the specialty for which they review. We feel strongly that if that protection were not there, and that protection has been handed down in the statutes that created the peer review process in the first place, then physicians would not want to participate in the process.

* * *

THE COURT: Maybe it could be explained to me, but I really have trouble with that concept. I have a hard time understanding how the opinions can be tested if the identities are not known. But I'll let the lawyers work on that.

* * *

THE COURT: Let me ask again, why do the doctors not want to be identified?

THE WITNESS: If the physicians are identified in every single case, and I think there was testimony presented earlier

that they do some 8,000 reviews a month, and if the physicians, every physician that had ever reviewed a medical record and rendered a decision or denied a service based on that medical record, if their names became public or generally made public, they just simply would not participate.

THE COURT: Why?

THE WITNESS: For fear of reprisals.

THE COURT: By who?

THE WITNESS: From patients, from attorneys. They would be in court all the time.

THE COURT: How would a lawyer reprise against them?

THE WITNESS: Do what?

THE COURT: How would a lawyer reprise against them?

THE WITNESS: They would bring them in court and have them testify in every case - -

THE COURT: And that's a reprisal?

THE WITNESS: To a physician who is in private practice, which most of these physicians are, any time out of their practice to spend a day in court is a tremendous - - you know, a tremendous impact.